II. The Feasibility and Desirability of Developing a Provider Rate Setting System that Establishes Minimum and Maximum Reimbursement for Health Care Services

Prepared by: Maryland Health Care Commission

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I. Introduction

In 2002, the Maryland General Assembly required the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) to study the feasibility of developing a provider rate setting system that would establish both minimum and maximum reimbursement.[1]

Physicians are unique in their ability to determine the volume of services they can provide. They are the gatekeepers and managers of the health care system; they direct and influence the type and amount of care their patients receive. (Physicians, for example, can order laboratory tests, radiological procedures, and surgery.) Moreover, the units of service for which physicians are paid under are frequently very small. The physician may, therefore, receive one fee for an office visit and a separate fee for individual services such as administering and interpreting x-rays--all of which can be provided in a single visit. Further, once a physician's practice is established, the marginal costs of providing more services are primarily those associated with the physician's time.

The question of establishing a payment system for health care providers that could, in many ways, parallel the system that is used for reimbursing acute care hospitals in the State has been debated before. A Uniform Payment System (UPS) that would have established a provider rate setting system for health care professionals was considered in the mid-1990s. The UPS could have led to the establishment of upper and lower limits on health care professional reimbursements. The proposal was abandoned prior to implementation due to technical difficulties and opposition from major provider groups and payers. This report reviews the original legislation, discusses technical elements of the payment system, and describes the final recommendations of the panel that was established to guide a design and possible implementation. In the final section, we discuss changes in the health care market since 1997 and make recommendations on whether these changes warrant reconsidering a system that could establish rates. This analysis focuses on the desirability of establishing a payment system based on standard FFS payment. Although the industry is beginning to examine other approaches, these methods are in their infancy.

II. Review of the Uniform Payment System (UPS)

Statutory Authority

The Health Care Access and Cost Commission (HCACC), a predecessor commission to MHCC, was required to develop a payment system for all health care practitioners in the State on or before January 1, 1999. The original enabling legislation, *Ch. 9, Acts 1993, § 1,* authorized the Commission to develop a "payment system for health care services." *Id.,*

[1] Laws of Maryland, 2002, Chapter 250, House Bill 805 – *Reimbursement of Health Care Providers.*

originally codified at *Health-General Article, Code Ann., §§19-1502(c)(8) and 19-1509.*[2] The intent behind this legislation was to grant the Commission the authority to develop a fee schedule governing payment for services rendered by all health practitioners in the State, including physicians. The Commission concluded that a payment system for physician and other health care services was neither feasible nor desirable. Accordingly, the Commission sought repeal of its authority to develop the payment system. In 2000, the General Assembly enacted legislation repealing the Commission's authority to set practitioner fees. That legislation, *Ch. 64, Acts 2000, §1*, took effect July 1, 2000. No statutory authority now exists in Maryland law to establish a payment system.

Payment System Design

In its enabling statute, HCACC was required to develop a payment system for all health care practitioners in the State on or before January 1, 1999. The establishment of a UPS was mandated for the purpose of enabling HCACC to attain its health care cost goals by providing the basis for measuring volumes and relative costs of health care services and adjusting payment levels. The system was intended to serve as a uniform basis for fee-for-service payment to practitioners by payers and individuals. Payers covered under the statute included insurers and HMO's, and all licensed health care practitioners such as physicians, dentists, social workers, therapists, and advanced practice nurses who bill independently.

The original statute was relatively straight forward. It directed HCACC to consider the underlying methodology of Medicare's Resource Based Relative Value Scale (RBRVS) when developing the payment system. Considerable time was spent evaluating if the Medicare RBRVS could be adopted by all payers for use in reimbursing all medical professionals. Reimbursement under the payment system was to be comprised of three numeric factors: a practitioner's resources to provide services relative to other practitioners; the value of a service relative to other health care services; and a conversion modifier to arrive at a dollar value. The statute envisioned that HCACC would establish the factors for practitioners' resources and the relative value of health care services. Payers and practitioners would negotiate the conversion modifier. By standardizing the method of payment and publicizing payer and provider conversion factors, purchasers and the public would have a better understanding of payment variations and thus would better shop based on payment differences among payers and providers.

The system established a framework for payment but it did not lead automatically to rate setting by the state. The HCACC could set conversion factors, effectively establishing minimums and maximums for payments, only when annual health care cost goals were not met and voluntary efforts to meet these goals failed. It was not clear in the law whether HCACC could establish reasonable levels on payments in the absence of health care cost control goals. The issue was discussed during the design phase without final agreement.

[2] These provisions were later recodified as Health-General Article, Code Ann., §§19-103(c)(9) and 19-136, respectively. *Ch. 702, Acts 1999, § 2.*

The system had a number of limitations that contributed to its demise. Employers that self-insure their employees' health could not have been compelled to use the system under state law.[3] These employers enjoy a broad preemption from state health insurance regulation under the federal Employer Related Insurance and Retirement Act (ERISA).[4] The preemption applies regardless of whether an employer self-administered the insurance benefits or pays an insurance company administrative services only (ASO) to administer the benefit on behalf of the employer. Although, advocates of the system argued that a UPS would benefit all purchasers, uncertainty as to coverage of the system raised doubts about its desirability. The ERISA preemption on self-insured firms is significant. In 2001, about 50 percent of enrollees with employer-sponsored coverage were enrolled in self-insured plans.[5] In the total private market which includes public employers and the individual market, self-insurance might account for about 35 to 40 percent of covered lives.

HCACC's enabling statute excluded capitated services[6] by law from coverage under the system. As a result, primary care physicians, such as family and general practice, internal medicine generalists, and pediatricians, would have found that the UPS did not cover a significant share of care. Other specialists that were subject to capitation would have been affected, although at a reduced level. The exclusion on capitated services created another hole in the system and further fragmented any coalition that could have developed around the UPS. Provider groups argued that the exclusion on capitated service meant that services that were in their judgment underpaid could never be brought into the system. Payers contended that capitation offered a means of cost control that paralleled a goal of the UPS. Both groups were correct in concluding that capitation and the unit price reimbursement mechanism of the UPS were incompatible.

The system was administratively complex. The UPS would have required providers to develop conversion modifiers for their practices. These modifiers would be used to convert the relative value units into a monetary value. Payers would develop conversion modifiers for each line of business such as their HMO, PPO, and indemnity products. Providers and payers would communicate this information to purchasers and consumers so comparison pricing could be made. The information technology requirements needed to implement the system were never estimated, although participants agreed that new IT investments would be significant.[7]

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[3] Self-insurance is a method of funding health benefits in which the employer assumes the risk up to a threshold amount after which a stop-loss insurance policy would cover losses, shielding the employer from further expense. Stop-loss policies are sold on a total loss basis or a per employee loss basis.

[4] Medical Expenditure Survey, Insurance Component 2001, Internet Tables, Table II.b.2.b. (1), available at www.ahrq.gov.

[5] Medical Expenditure Survey, Insurance Component 2001, Internet Tables, Table II.b.2.b. (1), available at http://www.meps.ahrq.gov/MEPSDATA/ic/2001/Tables_II/IC01_TIIA-E.pdf.

[6] Under capitation, payers reimburse providers a fixed payment per member per month. HMOs sometimes use capitation as a means for reimbursing primary care physicians. Laboratory and imaging centers also sometimes agree to be paid on a capitated basis for providing routine laboratory and radiology services. In the 1990s, capitation was also used for reimbursing certain specialty care providers.

[7] Health Care Access and Cost Commission, *Final Report of the Payment System Advisory Committee to the Health Care Access and Cost Commission,* December 1996.

Recommendations of the Advisory Panel on Payment System Design

The evaluation on implementing the payment system was scientific, exhaustive, and inclusive. The Payment System Advisory Committee (PSAC), an advisory workgroup composed of physician and other health care professionals, payers, and other interested parties evaluated alternatives, heard from national experts and crafted recommendations to HCACC. The HCACC contracted with a payment system development contractor, the Center for Health Economic Research (CHER) to work with the PSAC to assist in the design of the program. The Robert Wood Johnson Foundation awarded HCACC a $300,000 grant to fund a portion of the design effort.

CHER submitted three major design reports and a final report document. The PSAC considered and took action on over fifty major CHER recommendations for the design of the system. Although the PSAC adopted many of CHER's recommendations, the recommendation to establish floors and ceilings on reimbursement was not approved. CHER originally recommended that a conversion factor floor be established using Medicare's non-surgical conversion factor of $35 with a reasonable ceiling being commercial insurers' upper limit of reported conversion factor, which they reported to be about $65 in 1995.[8] The PSAC reached no consensus on setting floors and ceilings on the payment systems.[9] In all, HCACC spent more than three years working with the payer and provider community to devise a system. At the end of the three-year study, the HCACC concluded:

1. Enhanced competition appeared to have contained costs in the market place without implementing the payment system;
2. The UPS would not create a broad basis for systematically comparing fee-for-service and capitation arrangements;
3. Fee-for-service arrangements were declining as a means for reimbursing primary care practitioners;
4. The UPS would not set an external standard of reasonableness;
5. The market place was already working;
6. Implementation costs and disruption could be significant for some carriers and many practitioners who do not have the necessary technical knowledge or computer software to calculate their charges.

Public Comment at the Conclusion of the Payment System Debate

On September 30, 1997, HCACC held a special meeting for the purpose of providing the public with an opportunity to comment on the desirability of the Uniform Payment System. Ten people, all of whom were representing one or more organizations, presented oral testimony at the hearing; six favored outright repeal of the UPS, two favored implementation, one agreed with the staff's recommendation for delayed implementation and one person did not address

[8] Health Care Access and Cost Commission, *Final Report: Recommendations for the Design of the Uniform Physician Payment System*, Centers for Health Economic Research, June 1996, Cambridge MA, p 43.
[9] Health Care Access and Cost Commission, *Final Report of the Payment System Advisory Committee to the Health Care Access and Cost Commission, HCACC, Baltimore, MD,* December 1996, p 20-21.

the desirability issue. The organizations favoring repeal included the Maryland Association of Health Maintenance Organizations, Blue Cross Blue Shield of Maryland and The Medical and Chirurgical Faculty of Maryland.

HCACC Action

HCACC voted at the end of the study period to take the following actions:

1. Indefinitely delay the implementation of the payment system and establish a specific target to indicate when the benefit of implementing the UPS would outweigh the cost, i.e., where market failure had occurred and cost containment was necessary.
2. Prior to ever implementing the UPS, simplify the framework of the system design to make it more understandable for payers, practitioners, and the public. The idea of "unit pricing" for health care is a good one provided that all "users" know what the units mean.
3. Continue to monitor changes in methods of payment, payment incentives, and reasonableness of costs to compensation.
4. Implement the Payment System Advisory Committee's recommendation requiring payer rebundling edits and making standards for these edits available to the public on request.

The Inability of the UPS to Address Uncompensated Care

One of the justifications for adopting a payment system is that it could provide a framework for incorporating uncompensated care. During the debate on developing the UPS, the PSAC recommended that reimbursement of charity care would be most appropriately handled outside the payment system then under development. This decision may have contributed to providers' lack of enthusiasm for the payment system. Some practices, particularly university practices, are providers of last resort for many indigent patients. Data presented to MHCC as part of the implementation of Senate Bill 479, Maryland Trauma and Emergency Medical Response System – Funding and Structure[10] confirm that faculty practice plans continue to treat a high proportion of non-paying patients.[11] Faculty practice plans also serve a significant share of the Medicaid population where payments to health care professionals under that program appear barely adequate to cover fully allocated overhead expenses.[12] The provision of charity care increases the practice expense percentages at these faculty practice plans implicitly by driving down total revenues. However, the UPS would have calculated practice expenses net of bad debt and charity care. It should also be noted that uncompensated care costs are not reflected directly in Medicare's payment algorithms. Private payers would likely resist absorbing uncompensated care costs when they establish payment levels.[13] The PSAC recommended that uncompensated care be accounted for outside of the UPS.[14] To some

[10] See Laws of Maryland 2003, Chapter 250, Senate Bill 479.
[11] Health Services Cost Review Commission (HSCRC) and MHCC estimate that hospital and university-based physicians provided $40 million in uncompensated care in 2001.
[12] MHCC, ***Adequacy of Payments Relative to Costs and Implications For Maryland Health Care Providers***, MHCC, Baltimore, Maryland in 2003.
[13] Under Medicare, practice expense RVUs are calculated net of bad debt and charity care.
[14] HCCAC, Recommendations of the Payment System Advisory Committee, HCCAC 1996.

degree, Maryland's legislature acknowledged the issues of uncompensated care for trauma physicians through SB 479 that establishes the Maryland Physician Trauma Fund.

III. Changes in the Provider-Payer Environment Since 1998

Changes in the market place in Maryland have had a varying impact on Maryland health care providers. This section discusses three major trends in the market during the period from 1998 through 2003: (a) increased consolidation in the insurance market; (b) retreat of tightly managed care; and (c) the trends in total spending and payment rates.

Increased Consolidation

The health insurance market has become more consolidated since 1998. As shown in Table 1, the MHCC estimates that in 1998 about fifty-five payers were active in Maryland. By 2003, the number had dropped to thirty payers. During that same time period, MHCC estimates that the six largest private payers (CareFirst, MAMSI, Aetna U.S. Healthcare, CIGNA, United Healthcare, and Kaiser Permanente) covered over 95 percent of the privately insured population with the remaining twenty-four payers covering approximately 5 percent of the privately insured population in 2002.[15]

Table 1 – Number of Companies Selling in the Maryland Market

Year	Number of Insurers
1998	55
1999	54
2000	47
2001	35
2002	33
2003	29

Source: MHCC analysis of MIA annual filings. Companies selling disease specific insurance have been excluded from the analysis.

Major acquisitions and mergers have increased the concentration of market share in Maryland. Aetna began this trend with acquisitions of U. S. HealthCare, NYLCare, and Prudential in 1997-1998. The Maryland Blue Cross Blue Shield merged with National Capital Blue Cross and acquired the Delaware Blue Plan during 1999-2000. Most recently,

[15] MHCC uses the mean payments for individuals covered by insured and self-insured products.

United Healthcare announced plans to acquire Golden Rule and Mid-Atlantic Medical Services, Inc.

Many insurance companies with small shares of the market have left Maryland in the past 6 years.[16] The departures probably have not had a significant impact on market share of the large insurers, but the loss of any insurer can have a significant impact on a niche market or a particular region of the state. However, the mergers among the large payers appear to have impacted the market more dramatically than the departures of the smaller insurers. The cumulative impact of acquisitions, mergers, and market exits has been to consolidate a market among the six strongest payers. In 2003, five of the six major insurance companies offered a full range of products from indemnity to tightly managed care and served all markets from large employers to the individual market. The trend toward consolidation means that providers, like it or not, must contract with most large insurers because these payers control vast numbers of patients.

Decline of Tightly Managed Care

HMO market share crested in Maryland in 1998 when almost 50 percent of the privately insured population was covered by HMOs.[17] Since 2000, HMO market share has declined rather significantly, falling over 9 percent in 2001 and dropping another 7 percent in 2002. MHCC estimates that at the end of 2002 about 33 percent of the privately insured population were covered by HMOs.[18] HMOs responded to declines in enrollment by relaxing some of the requirements that patients must meet to gain access to care. Some of these changes resulted from legislative action, but most were in response to consumer and employer preferences and a willingness to pay, especially during the good economic times from 1998-2000. In 2003, HMO products are one line in a broad portfolio of products for large health insurers. As the options available to consumers expand, maintaining brand loyalty has become a higher priority than the success of any product line.

Table 2: Changes in HMO Enrollment by Source of Coverage, 1995–2002

	ALL PAYERS	MEDICARE	MEDICAID	PRIVATE
2001-02	NA	N/A	N/A	-7.1%
2000-01	-7.9%	-71.6%	8.5%	-9.3
1999-00	-0.6	-19.5	10.0	-2.0
1998-99	0.3	-3.1	11.4	-1.6
1997-98	7.1	5.3	79.4	-0.4
1996-97	10.1	125.0	30.4	5.6
1995-96	7.3	131.8	-0.1	6.6

[16] American Chambers Life, Anthem Health & Life, Centennial Life, Continental Life, CUNA, Educators Mutual, Employers Health, First Allmerica Financial, George Washington Health Plan (out of business), John Alden Life (dropped health branch), John Hancock Mutual (merged with Wellpoint), Metropolitan (merged), National Group Life, Nationwide, New England Mutual (merged with Great West), NY Life (acquired by Aetna), PFL Life, Pioneer Life, PM Group Life, Trustmark Life, US Life.
[17] MHCC, ***State Health Care Expenditures: Experience from 1999***, MHCC, Baltimore, Maryland, January 2002, p 14.
[18] MHCC: Internal estimates constructed by MHCC from Interstudy HMO enrollment data and tabulations from the March Current Population Survey.

In parallel with a decline in enrollment, merger and acquisitions reduced the number of HMOs. In 1997, the first year of HMO quality reporting, fifteen plans were featured. In 2003, eight plans reported.[19] The consolidation of the HMO market should be viewed as a by-product to the consolidation of the overall insurance market. Although the HMO sub-market is best characterized as concentrated, new entrants such as Coventry, and established independents like Preferred Health Network, have been able to remain competitive in the market, albeit with small market shares.

The rise of capitation was cited by HCACC as a reason for not moving forward with the UPS. In 1995 and 1996, capitation as a form of payment was in ascendancy. Capitated payment has declined since 1997 for two reasons. First, HMO market share is down. Second, HMOs have moved away from capitated payment as a means for reimbursing health professionals, particularly specialists. HMOs have moved away from specialty care capitation because of the difficulty to accurately forecast specialty care use and, perhaps, because of opposition among providers. The collapse of several large physician organizations that could manage capitated payments contributed to the reduced use of this method of payment.[20]

One indicator of the decline in capitation can be found by examining the change in the percentage of specialty care capitated services in the MHCC's Medical Care Data Base. The results in Table 3 show the volume of capitated specialty care encounters as a share of all encounters declining since 1999. Capitated encounters as a share of all services fell from just under 15 percent in 1999 to just over 9 percent in 2002. The most dramatic decline occurred between 2001 and 2002 when the share fell by 2.5 percentage points.

Table 3 – Capitated Specialty Care Services as a Percent of All Services in the Medical Care Data Base

Year	Percent of Total Services
1999	16.9%
2000	16.6
2001	15.4
2002	12.9

Source: MHCC analysis of MIA annual filings. Companies selling disease specific insurance have been excluded from the analysis.

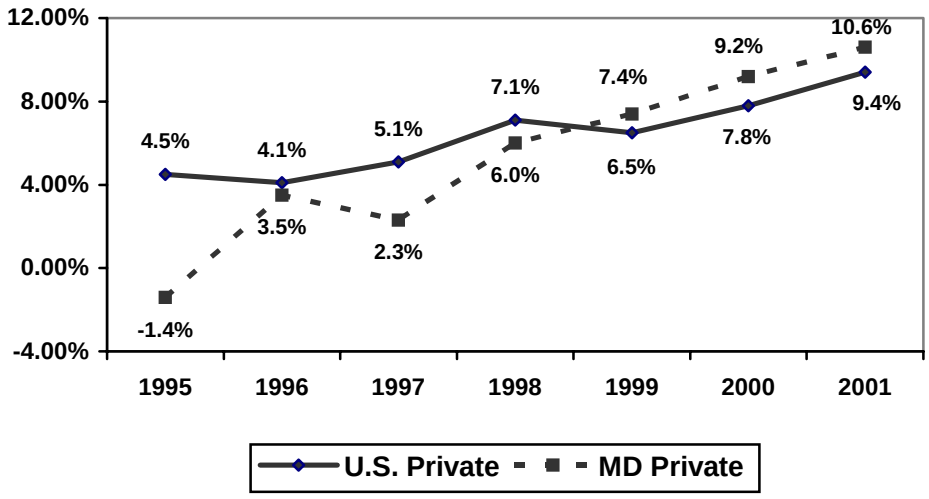
[19] United HealthCare of the Mid-Atlantic sells in the private market; however, it was exempted from reporting because the majority of its enrollees are Medicaid beneficiaries.

[20] In the late 1990s, large physician organizations closed. Only large physician practices can assume the risk associated with global capitation that some HMOs offered at that time.

Trends in Total Spending and Payments Rates

MHCC has reported a steady increase in overall private sector health care spending since 1999. For 2001, MHCC reported that overall private sector health care spending grew by nearly 11 percent. The growth in private spending has exceeded the comparable rate for the U.S. over the past three years. Maryland's rate of increase in the four prior years (1995-98) was below the U.S. rate in each of those years. The causes for the accelerating growth have not been precisely pinpointed. Accelerating prescription drug spending is a factor. However, the accelerated growth rate parallels declines in HMO enrollment. As enrollees moved from more managed to less managed delivery systems beginning in the late 1990s, it is not unreasonable to expect that easier access to services lead to higher growth than would have otherwise occurred. For 2002, the MHCC expects that private spending will grow at a near double digit rate.

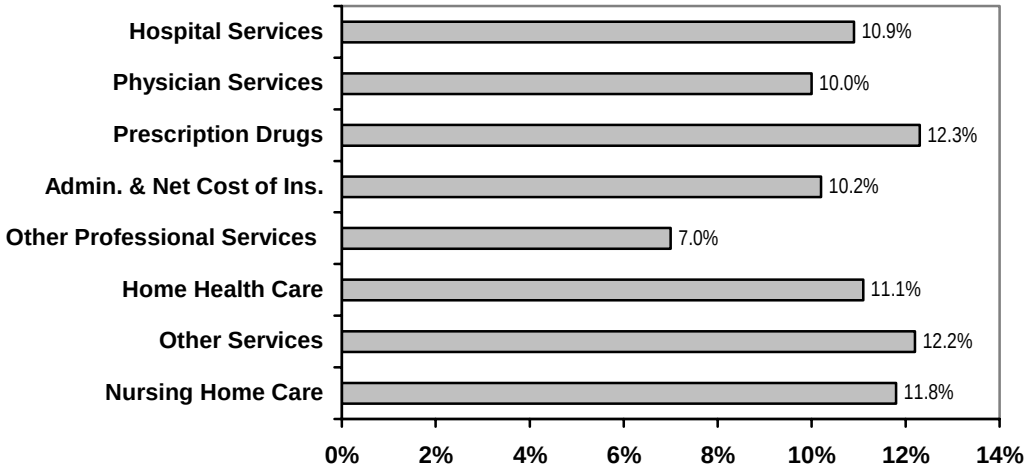
Figure 1-- Maryland and U.S. Private Sector Health Care Spending 1995-2001



Private sector spending on physician services has grown significantly over the past three years, overall by a cumulative 25 percent. In 2001, rates of increase for physician and other professional health care spending were about 10 percent and 7 percent respectively. Although these sectors grew rapidly, their growth rates were smaller than hospital outpatient and prescription drugs. Rapid rates of increase in health care spending translate into increases in health care premiums in future years and these increases are consistent with the 12-14 percent premium increases reported nationally for 2002-2003.[21]

[21] Kaiser Family Foundation, ***Employer Health Benefits 2003 Annual Survey,*** *Kaiser Family Foundation*, ***2003*** available at http://www.kff.org/insurance/ehbs2003-abstract.cfm. Milliman USA predicted the rate of increase for HMOs nationally was 11-16 percent, www.milliman.com. Hewitt & Associates estimated that premiums jumped 14.7 percent in 2003, www.hewitt.com

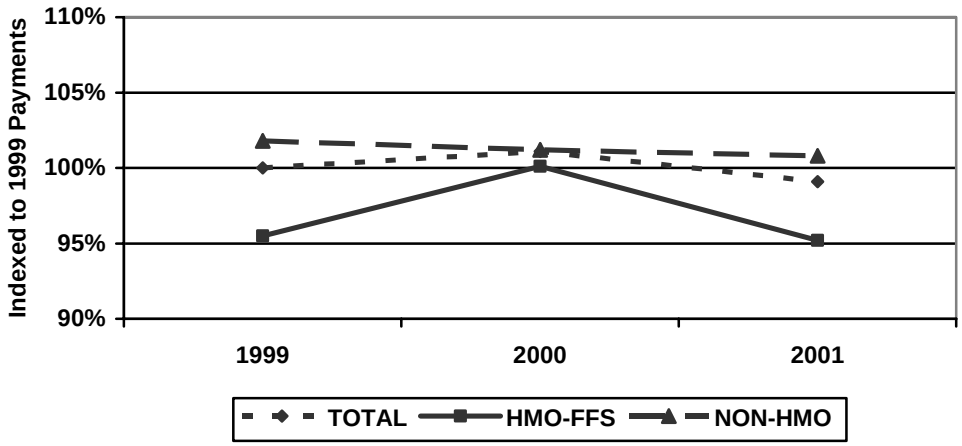
Figure 2 -- Rate of Increase in Maryland Private Health Care Spending for 2001



Physician and other health care professional expenditures accounted for approximately 40 percent of total private spending. Prior studies conducted by MHCC suggested that increases in spending for physician and other health care professionals from 1999-2001 were driven by increases in utilization and not due to increases in fees. MHCC found that overall fees through 2001 had not changed substantially since 1999.[22] The 10 percent increase in physician spending growth from 2000 to 2001 was due almost entirely to growth in volume of care, not to price (fee) increases. Volume of care increased in almost all categories of service. For 2001, MHCC found that private rates averaged 2 percent below Medicare rates. This was a small decline from 2000, but that change was due mainly to increases in Medicare's rates, not changes in rates paid by private payers. Medicare raised its physician payment rates 5 percent in 2001. As shown in Figure 3, private insurers' rates have been essentially unchanged since 1999.

[22] MHCC: ***Practitioner Utilization: Trends Within Privately Insured Patients***. MHCC - Baltimore, Maryland, 2003.

Figure 3 -- Change in Private Sector Physician Payment Rates 1999-2001



On balance, changes in the health care market have had a mixed impact on physicians. In 2003, physicians and other health care providers face a more consolidated insurer market. It is unlikely that any but the largest practices in the state have much control over price. The consequences for most practices of not contracting with the largest insurers are significant. On the other hand, the grip of tightly managed care on Maryland physicians has weakened. Use of capitated payment has declined. Though few Maryland physician practices can dictate price, there is some evidence that physicians feel they have regained control of clinical decision-making. A study by the Center for Health System Change found that as managed care plans eased restrictions in the late 1990s, the proportion of specialist physicians who believed they had enough control over clinical decisions to meet patients' needs increased by 13 percent from 1997 to 2001.[23] This survey was conducted in twelve health care markets across the U.S., but the results have relevance to Maryland, where a significant roll-back of tightly managed care has occurred.

The rate of growth in health care spending including physician services is troubling, especially in the face of static payment levels. Practice expense and professional liability costs are on the rise. A companion study under the HB 805 requirements found that private sector reimbursement is adequate to cover fully allocated expense with sufficient slack to cover income. However, reimbursement as a percent of fully allocated overhead is lower than for the U.S. overall. That analysis points to significant under-funding of Medicaid reimbursement as a more significant problem.[24] The study went on to point out that with overhead expense absorbing an increasing share of payment, physicians and other practitioners will find it difficult to absorb uncompensated care losses or expand their volume of Medicaid patients.

[23] Hargraves J. Lee, Pham H. Hoangmai, ***Back in the Driver's Seat: Specialists Regaining Autonomy,*** Tracking Report No. 7, Center for Study Health System Change, Washington, DC 2003

[24] MHCC: ***Adequacy of Payments Relative to Costs and Implications For Maryland Health Care Providers,*** Baltimore, Maryland in 2003.

IV. Conclusions and Recommendations

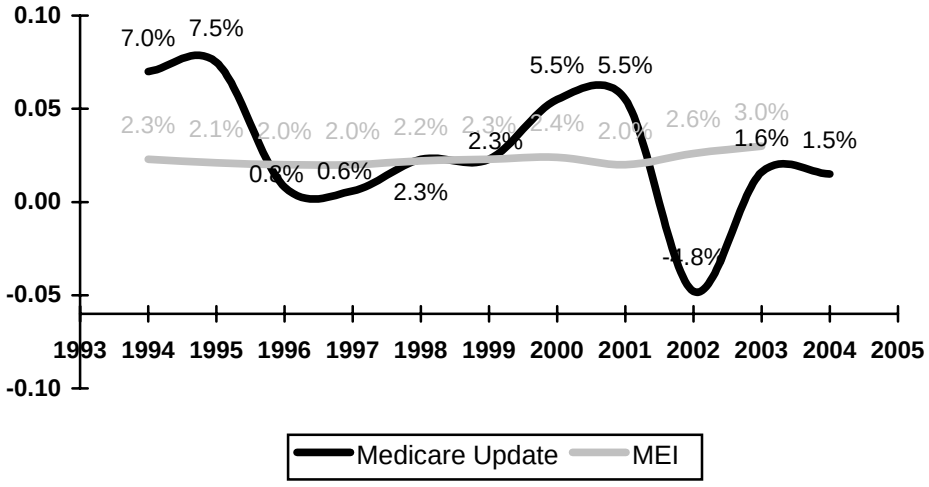
At a time of rapid spending growth and resulting upward pressure on private health care premiums, it is difficult to recommend reforms that simply raise fees without offering simultaneous opportunities to produce saving. Changes that increase payments to physicians will increase premiums or increase patients' out-of-pocket spending. Nonetheless, financial burdens on private practices are real and appear at best static and at worst deteriorating. MHCC has not detected widespread interest in establishing a new system. Although markets have evolved, many of the same impediments to earlier development remain in 2003.

The Legislature could establish minimums and maximums for all services based on Medicare rates. This approach would eliminate a contentious payment system development cycle and would use a well established system as the basis for setting payments. Simply pegging all private payment to Medicare payment rates would be a mistake without a very significant transition period, because setting thresholds relative to Medicare across the entire range of services would lead to large shifts in reimbursement among specialties. Recent analyses by MHCC show that private payers currently reimburse physicians more favorably than Medicare for procedures and tests, but less favorably for office visits. A transition period would dampen income shifts that would otherwise occur. Some specialty groups would likely oppose this approach, with or without a transition, because of the reimbursement reductions that would follow. ***The MHCC does not favor this approach at this time.***

The MHCC does not believe that development of a payment system or even the establishment of across-the-board payment minimums and maximums is desirable at this time for the following reasons:

1. A payment system based on standard unit price derived from RVUs offers few tools to regulate volume or quality. The Medicare Fee Schedule (MFS), the most developed system of payment based on RVUs, was intended to promote equity of reimbursement across regions of the country and among physicians. One thing the MFS was not designed to do, however, was control costs. The system has not changed the financial incentives in fee-for-service (FFS) which may promote overuse. A new payment system based on FFS would not offer significant cost control. After more than a decade of operation, one of the biggest challenges to the MFS has been how to update payments while controlling growth in volume. Both the Volume Performance Standard (VPS), in effect from 1992 to 1998 and the Sustainable Growth Rate (SGR) have lead to instability in update factors. As shown in Figure 5, the underlying measure of inflation as measured by the Medicare Economic Index (MEI, a measure of inflation in physicians' per-unit cost) ranged from 2.0 to 3.0 percent; however, the range in MFS annual updates has been significantly more volatile.

Figure 5 -- Medicare Fee Schedule Updates and Annual Change in the Medicare Economic Index



2. Development of the original UPS produced little consensus and no result. After several years of study, thousands of staff hours, and the advice of numerous outside experts, the Payment System Advisory Committee failed to reach consensus, development was halted, and the statute was repealed. MHCC does not recommend resurrecting a payment system based on unit prices at this time. MHCC sees no evidence that payers or providers have reached agreement on the principles that could lead to sound system development. It should be emphasized that the advisory panel reached no agreement on minimum and maximum payment levels.

3. The payment system would not fix some of the most complex problems and would add additional administrative expense, at least initially. The UPS could not address the problem of uncompensated care, nor could the system necessarily cover all payers, particularly self-insured employers. Reimbursement under capitated arrangements would have to be resolved. Capitation, unlike FFS, stacks the financial incentives toward underuse. Devising a system that could simultaneously set FFS payment rates and shadow price capitation payments would be difficult to achieve.

If the system is to be implemented, startup costs will be significant. Many practices are now absorbing significant Health Insurance Portability and Accountable Act, 1996 (HIPAA) implementation expense and the added cost of payment system changes would not be welcome. Work by the advisory committee during the HCACC study period identified significant administrative expenses that the insurers and providers would have to absorb. Offsetting costs associated with greater standardization of payment would be recovered, but only in the out years.

MHCC recommends that the Legislature continue to monitor payment levels and to set payment levels where payment imbalances or predatory payment practices exist. Pegging reimbursement levels to Medicare rates for these services may serve to set a signal on what reasonable floors are for payment in the overall market. Setting a private floor and ceiling to Medicare's rate rather than a payer's own rates makes sense because these rates are public and readily available to the provider community.

Several other reimbursement approaches that are under development at CMS and in the private sector may offer better systematic approaches for balancing quality and efficiency. These systems set a fixed price for a bundle of services but allow the provider the freedom to make decisions about the volume of services provided to the patient. MHCC and HSCRC are monitoring these developments and will alert the Legislature on the success of these demonstrations.[25]

In considering whether to attempt to change the current system for setting physician payments, the Legislature should confront the prospect that fees paid per service for the next several years could continue to be stable. Maintaining access to care for Maryland residents is a key consideration in assessing current fee levels. At this time, practitioner supply seems adequate and most providers seem willing to contract with the major insurers. However, the lack of more timely data makes it hard to know whether, and to what extent, problems exist overall. More timely data on that issue would be an important improvement over the current situation and could assist the Legislature in its deliberations.

[25] CMS has experimented with systems that would pay hospitals and physicians a bundled payment, for example see ***Medicare Participating Heart Bypass Center: Extended Evaluation,*** CMS, 1998, Http://www.cms.hhs.gov/researchers/reports/1998/oregon2.pdf. A number of private payers are currently experimenting with systems that reimburse providers for treating a specific spell of illness.